		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040931

Facility Name: COUNTRYSIDE CARE CENTRE

Address: 2330 W. GALENA (Number) AURORA (City) 60506 (Zip Code)

County: KANE

Telephone Number: (630) 896-4686 **Fax #** (630) 896-7868

IDPA ID Number: 36-3961908

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	111	Skilled (SNF)	111	40,626	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,868	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,494	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,640	1,681	5,807	12,128	8
9	SNF/PED					9
10	ICF	37,661	13,761	2,403	53,825	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,301	15,442	8,210	65,953	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4) 86.22%

D. How many bed-hold days during this year were paid by Public Aid? 40 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 07/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 2600

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	293,386	47,566	13,022	353,974		353,974	(113)	353,861			1
2	Food Purchase		247,208		247,208	(4,964)	242,244	(3,584)	238,660			2
3	Housekeeping	224,841	27,857	0	252,698		252,698	822	253,520			3
4	Laundry	83,733	36,357	2,379	122,469		122,469	(595)	121,874			4
5	Heat and Other Utilities			170,133	170,133		170,133	0	170,133			5
6	Maintenance	29,963	41,576	78,394	149,933		149,933	2,215	152,148			6
7	Other (specify):*			26,268	26,268		26,268	0	26,268			7
8	**TOTAL General Services**	631,923	400,564	290,196	1,322,683	(4,964)	1,317,719	(1,255)	1,316,464			8
	B. Health Care and Programs											
9	Medical Director			18,469	18,469		18,469	0	18,469			9
10	Nursing and Medical Records	2,560,964	138,891	288,360	2,988,215		2,988,215	(13,572)	2,974,643			10
10a	Therapy	75,868		0	75,868		75,868	0	75,868			10a
11	Activities	163,001	8,665	11,374	183,040		183,040	(556)	182,484			11
12	Social Services	54,079		1,643	55,722		55,722	0	55,722			12
13	Nurse Aide Training			828	828		828	0	828			13
14	Program Transportation			2,398	2,398		2,398	0	2,398			14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	2,853,912	147,556	323,072	3,324,540		3,324,540	(14,128)	3,310,412			16
	C. General Administration											
17	Administrative	140,117		627,420	767,537		767,537	(630,803)	136,734			17
18	Directors Fees			0				0				18
19	Professional Services			255,018	255,018		255,018	62,828	317,846			19
20	Dues, Fees, Subscriptions & Promotions			153,836	153,836		153,836	(110,273)	43,563			20
21	Clerical & General Office Expense	142,168	70,548	82,443	295,159		295,159	109,296	404,455			21
22	Employee Benefits & Payroll Taxes			514,245	514,245	4,964	519,209	0	519,209			22
23	Inservice Training & Education			14,607	14,607		14,607	0	14,607			23
24	Travel and Seminar			1,091	1,091		1,091	12,329	13,420			24
25	Other Admin. Staff Transportation			4,341	4,341		4,341	0	4,341			25
26	Insurance-Prop.Liab.Malpractice			11,317	11,317		11,317	122,999	134,316			26
27	Other (specify):*			669,983	669,983		669,983	(669,983)				27
28	**TOTAL General Administration**	282,285	70,548	2,334,301	2,687,134	4,964	2,692,098	(1,103,607)	1,588,491			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,768,120	618,668	2,947,569	7,334,357		7,334,357	(1,118,990)	6,215,367			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			126,027	126,027		126,027	109,212	235,239			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			118,071	118,071		118,071	326,905	444,976			32
33	Real Estate Taxes			95,040	95,040		95,040	0	95,040			33
34	Rent-Facility & Grounds			856,321	856,321		856,321	(840,254)	16,067			34
35	Rent-Equipment & Vehicles			33,065	33,065		33,065	8,141	41,206			35
36	Other (specify):*							0				36
37	TOTAL Ownership			1,228,524	1,228,524		1,228,524	(395,996)	832,528			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		165,144	281,446	446,590		446,590	0	446,590			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			114,742	114,742		114,742	0	114,742			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		165,144	396,188	561,332		561,332		561,332			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,768,120	783,812	4,572,281	9,124,213	0	9,124,213	(1,514,986)	7,609,227			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(77,182)	30		9
10	Interest and Other Investment Income	(22,071)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,584)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(20,437)	21		18
19	Entertainment	0	20		19
20	Contributions	(3,840)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(2,302)	19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(669,983)	27		24
25	Fund Raising, Advertising and Promotional	(89,575)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(18,682)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	3,124	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (904,532)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(559,613)	G 6 & 6A	34
35	Other- Attach Schedule	(50,841)	PG. 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (610,454)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ ########		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS **Page 5A**

Facility Name COUNTRYSIDE CARE CENTRE
ID# 0040921
Report Period Beginning: 01/01/2009
Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.			**Line 1**	(111)
1	**Day Care**	0	0	**Line 2**	(5,584)
2	**Other Care for Outpatients**	0	0	**Line 3**	822
3	**Governmental Sponsored Special Programs**	0	0	**Line 4**	(909)
4	**Non-Patient Meals**	0	2	**Line 5**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 6**	2,231
6	**Rented Facility Space**	0	34	**Line 7**	0
7	**Sale of Supplies to Non-Patients**	0	10	**Line 8**	(1,369)
8	**Laundry for Non-Patients**	0	4	**Line 9**	0
9	**Non-Straightline Depreciation**	(77,182)	30	**Line 10**	(25,475)
10	**Interest and Other Investment Income**	(22,071)	32	**Line 10a**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 11**	(896)
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 12**	0
13	**Sales Tax**	(5,584)	2	**Line 13**	0
14	**Non-Care Related Interest**	0	32	**Line 14**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 15**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 16**	(24,031)
17	**Non-Care Related Fees**	0	20	**Line 17**	(22,359)
18	**Fines and Penalties**	(20,437)	21	**Line 18**	0
19	**Entertainment**	0	20	**Line 19**	(2,306)
20	**Contributions**	(3,840)	20	**Line 20**	(112,497)
21	**Owner or Key-Man Insurance**	0	22	**Line 21**	(24,719)
22	**Special Legal Fees & Legal Retainers**	(2,302)	19	**Line 22**	0
23	**Malpractice Insurance for Individuals**	0	26	**Line 23**	0
24	**Bad Debt**	(669,983)	27	**Line 24**	0
25	**Fund Raising, Advertising and Promotional**	(80,575)	20	**Line 25**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 26**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 27**	(669,983)
28	**Yellow Page Advertising**	(18,682)	20	**Line 28**	(830,839)
29	**Non-Paid Workers**	0	0	**Line 29**	(856,140)
30	**Donated Goods**	0	0	**Line 30**	(77,446)
31	**Amortization Expense**	0	0	**Line 31**	0
32	PAGE 5 - LINE 35 VACATION ACCRUAL	(113)	1	**Line 32**	(22,071)
33	PAGE 5 - LINE 35 VACATION ACCRUAL	822	3	**Line 33**	0
34	PAGE 5 - LINE 35 VACATION ACCRUAL	(589)	4	**Line 34**	0
35	PAGE 5 - LINE 35 VACATION ACCRUAL	(909)	6	**Line 35**	0
36	PAGE 5 - LINE 35 VACATION ACCRUAL	(25,475)	10	**Line 36**	0
37	PAGE 5 - LINE 35 VACATION ACCRUAL	(536)	11	**Line 37**	(99,243)
38	PAGE 5 - LINE 35 VACATION ACCRUAL	(22,322)	17	**Line 38**	0
39	PAGE 5 - LINE 35 VACATION ACCRUAL	(3,693)	21	**Line 39**	0
40	PAGE 5 - LINE 29 DEFERRED MAINTENANCE	3,124	6	**Line 40**	0
41				**Line 41**	0
42				**Line 42**	0
43				**Line 43**	0
44				**Line 44**	0
45				**Line 45**	(955,177)

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(113)	0	0	0	0	0	0	0	0	0	0	(113)	1
2	Food Purchase	(3,584)	0	0	0	0	0	0	0	0	0	0	(3,584)	2
3	Housekeeping	822	0	0	0	0	0	0	0	0	0	0	822	3
4	Laundry	(595)	0	0	0	0	0	0	0	0	0	0	(595)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,215	0	0	0	0	0	0	0	0	0	0	2,215	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,255)	0	0	0	0	0	0	0	0	0	0	(1,255)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(23,475)	9,903	0	0	0	0	0	0	0	0	0	(13,572)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(556)	0	0	0	0	0	0	0	0	0	0	(556)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	(24,031)	9,903	0	0	0	0	0	0	0	0	0	(14,128)	16
	C. General Administration													
17	Administrative	(22,322)	(608,481)	0	0	0	0	0	0	0	0	0	(630,803)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,302)	4,940	60,190	0	0	0	0	0	0	0	0	62,828	19
20	Fees, Subscriptions & Promotions	(112,097)	1,824	0	0	0	0	0	0	0	0	0	(110,273)	20
21	Clerical & General Office Expenses	(24,130)	130,076	3,350	0	0	0	0	0	0	0	0	109,296	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,329	0	0	0	0	0	0	0	0	0	12,329	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	5,876	117,123	0	0	0	0	0	0	0	0	122,999	26
27	Other (specify):*	(669,983)	0	0	0	0	0	0	0	0	0	0	(669,983)	27
28	**TOTAL General Administration**	(830,834)	(453,436)	180,663	0	0	0	0	0	0	0	0	(1,103,607)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(856,120)	(443,533)	180,663	0	0	0	0	0	0	0	0	(1,118,990)	29

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(77,182)	10,431	175,963	0	0	0	0	0	0	0	0	109,212	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,071)	0	348,976	0	0	0	0	0	0	0	0	326,905	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	16,067	(856,321)	0	0	0	0	0	0	0	0	(840,254)	34
35	Rent-Equipment & Vehicles	0	8,141	0	0	0	0	0	0	0	0	0	8,141	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(99,253)	34,639	(331,382)	0	0	0	0	0	0	0	0	(395,996)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(955,373)	(408,894)	(150,719)	0	0	0	0	0	0	0	0	(1,514,986)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe COUNTRYSIDE CARE CENTRI # 0040931 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6I | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LT		MANAGEMENT
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT	
				COUNTRYSIDE HEALTHCARE CENTRE		
					ROSEMONT, IL	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
V	16	NURSING	$	FHC ENTERPRISES INC	%	9,903	$ 9,903	1	9903
V	17	ADMINISTRATIVE	627,420	" " MJC BELLOWS OWNS 1.5% OF THIS FACILIT		38,939	(588,481)	2	-603481
V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISE		4,940	4,940	3	4940
V	20	DUES & SUBSCRIPTIONS		" "		1,824	1,824	4	1824
V	21	CLERICAL		" "		130,076	130,076	5	130076
V	24	TRAVEL		" "		12,329	12,329	6	12329
V	26	INSURANCE		" "		5,876	5,876	7	5876
V	28	DEPRECIATION		" "		10,431	10,431	8	10431
V	34	RENT		" "		16,067	16,067	9	16067
V	25	RENT/EQUIPMENT & VEH		" "		8,141	8,141	10	8141
V								11	
V								12	
V								13	
Total			$ 627,420			$ 238,526	$ * (488,894)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	34	RENT	$ 856,321	COUNTRYSIDE HEALTHCARE CENTRE		$	$ (856,321)	15	-856321
16	V	19	ACCOUNTING FEES		" "		8,700	8,700	16	8700
17	V	19	LEGAL FEES		" "		240	240	17	240
18	V	19	OTHER PROFESSIONAL		" "		51,250	51,250	18	51250
19	V	21	BANK CHARGES		" "		3,350	3,350	19	3350
20	V	26	GENERAL INSURANCE		" "		93,471	93,471	20	93471
21	V	26	MORTGAGE INSURANCE		" "		23,652	23,652	21	23652
22	V	30	DEPRECIATION - BLDG/IMP		" "		166,207	166,207	22	166207
23	V	30	DEPRECIATION - EQP/FURN		" "		9,756	9,756	23	9756
24	V	32	AMORTIZATION - MTG COST		" "		2,972	2,972	24	2972
25	V	32	INTEREST - MORTGAGE		" "		346,004	346,004	25	346004
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 856,321			$ 705,602	$ * (150,719)	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

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STATE OF ILLINOIS

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

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STATE OF ILLINOIS

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6D

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STATE OF ILLINOIS

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	1.5%	SEE ATTACHED	3.06	8.92	SALARY	18,939	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 18,939		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 10700 W. HIGGINS ROAD, STE. 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	480,456	10	$ 72,138	$ 72,138	65,953	$ 9,903	1
2	17	ADMINISTRATIVE	PATIENT DAYS	480,456	10	137,966	137,966	65,953	18,939	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	480,456	10	35,987		65,953	4,940	3
4	20	DUES AND SUBSCRIPTION	PATIENT DAYS	480,456	10	13,291		65,953	1,824	4
5	21	CLERICAL	PATIENT DAYS	480,456	10	742,182	614,693	65,953	101,881	5
6	21	CLERICAL	HOURS	1	1	28,195	28,195	1	28,195	6
7	24	TRAVEL	PATIENT DAYS	480,456	10	89,811		65,953	12,329	7
8	26	INSURANCE	PATIENT DAYS	480,456	10	42,804		65,953	5,876	8
9	30	DEPRECIATION	PATIENT DAYS	480,456	10	75,987		65,953	10,431	9
10	34	RENT	PATIENT DAYS	480,456	10	117,045		65,953	16,067	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	480,456	10	59,305		65,953	8,141	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,414,711	$ 852,992		$ 218,526	25

Print Preview

Print Page 8A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - COUNTRYSIDE HEALTHCARE CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE	VARIES	10/97	4,826,200	4,719,941	10/32	0.0745	346,004	2
3	GMAC		X	LOAN COST	35 YR AMOR	10/97	104,006	94,099			2,972	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	LINE OF CREDIT	VARIES	12/96	265,000	1,225,000	DEMAND	PRIME+	48,437	6
7	LOAN FROM PARTNERS	X		WORKING CAPITAL	VARIES	06/99	108,600	108,600	DEMAND	PRIME+	9,801	7
8	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/98	498,989	1,325,000	DEMAND	PRIME+	59,833	8
9	TOTAL Facility Related						$ 5,802,795	$ 7,472,640			$ 467,047	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,802,795	$ 7,472,640			$ 467,047	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	90,192	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	92,112	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,920	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	93,120	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	95,040	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	86,678	8
	1996	88,981	9
	1997	87,583	10
	1998	89,211	11
	1999	92,112	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,536 B. General Construction Type: Exterior BRICK Frame STEEL CNST Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 0 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	130,679	1981	$ 98,000	1
2	754 BASIS ADJ		1982	16,345	2
3	TOTALS	130,679		$ 114,345	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	209		1981		$ 2,111,156	$ 0	30	$ 70,059	$ 70,059	$ 1,359,973	4
5											5
6	754 BASIS AJ			1992	403,542	12,811	31.5	12,811		108,894	6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	*****RELATED PARTY - COUNTRYSIDE HEALTHCARE										9
10	BUILDING IMPROVEMENTS			1982	40,076		15			40,076	10
11	VARIOUS IMROVEMENTS			1983	26,282		15			26,282	11
12	VINYL TILING			1984	76,250	1,990	20	3,813	1,823	62,904	12
13	ROOF REPAIR			1985	6,644	349	20	332	(17)	5,146	13
14	VARIOUS IMPROVEMENTS			1986	1,609	85	15	107	22	1,549	14
15	VARIOUS IMPROVEMENTS			1987	36,433	1,157	20	1,822	665	24,597	15
16	BLACK TOP PAVING			1988	1,594	106	15	106		1,325	16
17	HOT WATER PIPING			1988	5,837	185	31.5	185		2,259	17
18	ROOFING IMPROVEMENTS			1989	51,879	1,647	31.5	1,647		19,284	18
19	SHOWER STALLS			1990	7,000	222	31.5	222		2,331	19
20	PAVING			1990	7,930	529	15	529		5,554	20
21	VARIOUS IMPROVEMENTS			1991	24,486	777	20	1,224	447	11,636	21
22	VARIOUS IMPROVEMENTS			1992	43,773	1,390	31.5	1,390		11,679	22
23	VARIOUS IMPROVEMENTS			1993	13,286	421	31.5	421		3,307	23
24	VARIOUS IMPROVEMENTS			1993	40,598	1,041	39	1,041		7,589	24
25	VARIOUS IMPROVEMENTS			1994	221,766	5,494	39	5,494		33,928	25
26	VARIOUS IMPROVEMENTS			1994	55,030	4,167	15	4,167		27,082	26
27	KITCHEN REMODEL/SIGNS			1995	32,836	842	39	842		4,984	27
28	ELECTRICAL & LIGHTING			1995	31,634	811	39	811		3,544	28
29	ROOFING/DOORS/DUCTWORK			1995	15,211	390	39	390		1,720	29
30	ROOF REPAIRS/FIRE DAMPERS			1996	4,300	110	39	110		537	30
31	BLACK TOP PAVING			1996	3,400	87	39	87		359	31
32	DUCTWORK			1996	8,584	220	39	220		889	32
33											33
34					ADJ TO SL	72,999			(72,999)		34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 107,830		$ 107,830	$	$ 1,767,428	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	RMOVE & REPLACE HVAC ROOF UNITS			1998	28,363	727	39	727		1,666	9
10	ROOF REPAIRS - PATCHING			1998	6,500	167	39	167		480	10
11	STAINLESS DUCTWORK - KITCHEN EXHAUST			1998	3,987	102	39	102		302	11
12	BOILER			1998	6,556	168	39	168		441	12
13	WALLCOVERING, CARPETING, ARCHITECT WRK			1999	58,243	2,118	27.5	2,118		4,148	13
14	WALLCOVERING, ALARMS/ELECTRIC WORKS			1999	27,515	1,000	27.5	1,000		1,876	14
15	REMODEL KITCHEN/WALLCOVERINGS/DRYWALL			1999	11,104	404	27.5	404		724	15
16	DINING RMS/WASHROOM -REMODEL/NEW ROOF			1999	165,984	6,035	27.5	6,035		10,311	16
17	LANDSCAPING/SECURITY PROJECT			1999	38,968	1,417	27.5	1,417		2,303	17
18	CONCRETE PATIO/DRAINAGE/DUCTWORK			1999	26,186	952	27.5	952		1,468	18
19	FLOOR TILES/WALLCOVERING/WALL REPAIRS			1999	127,185	4,624	27.5	4,624		6,744	19
20	IRRIGATION SYSTEM/BTY STATIONS			1999	26,058	947	27.5	947		1,302	20
21	NEW ADDITION/EXHAUST FANS/INTERIOR WRK			1999	843,269	30,661	27.5	30,661		37,053	21
22	REMODEL - OFFICES/BATHROOMS/DINING			2000	72,465	2,525	27.5	2,525		2,525	22
23	FIRE DAMPERS AND FLOOR GRILLES			2000	5,226	182	27.5	182		182	23
24	DOORS/LAUNDRY RM/CORRIDOR - REMODEL			2000	64,257	1,461	27.5	1,461		1,461	24
25	ELEVATOR OPERATING PANEL			2000	4,490	102	27.5	102		102	25
26	LINT COLLECTOR/REMODELING PLANS			2000	7,595	127	27.5	127		127	26
27	SPRINKLER SYSTEMS			2000	8,550	143	27.5	143		143	27
28	ELEVATOR WANDERGUARD SYSTEM			2000	5,282	72	27.5	72		72	28
29	KITCHEN REMODELING/CARPETING			2000	82,957	1,132	27.5	1,132		1,132	29
30	HOT WATER REC. - MIXING VALVE & CIRCUIT SETTERS			2000	8,604	91	27.5	91		91	30
31	FRESH AIR INTAKES/ROOF STANDS			2000	23,244	247	27.5	247		247	31
32	FIRE ALARM/ DOORS			2000	6,184	66	27.5	66		66	32
33	PARKING LOT EXPANSION			2000	35,624	378	27.5	378		378	33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 55,848		$ 55,848	$	$ 75,344	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	GENERATORS			2000	92,626	702	27.5	702		702	9
10	LANDSCAPING			2000	12,625	420	15	420		420	10
11	RESIDENT ROOM REMODELING & FURNISHING			2000	67,311	510	27.5	510		510	11
12	PATIENT WANDERING SYSTEM			2000	14,541	110	27.5	110		110	12
13	AIR FREE LINT FILTER			2000	1,399	11	27.5	11		11	13
14	NEW ROOF			2000	20,995	96	27.5	96		96	14
15	RESIDENT ROOM REMODELING & FURNISHING			2000	103,610	471	27.5	471		471	15
16	ROOF REPAIRS			2000	3,300	15	27.5	15		15	16
17	ROOF REPAIR & METACAULK FIRE STOP			2000	11,211	17	27.5	17		17	17
18	ROOF TOP HVAC UNIT			2000	7,350	11	27.5	11		11	18
19	ELECTRICAL WORK/RESIDENT RMS REMODEL			2000	109,053	166	27.5	166		166	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 2,529		$ 2,529	$	$ 2,529	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 555,122	$ 108,064	$ 43,379	$ (64,685)	3-15 YRS	$ 126,687	37
38	Current Year Purchases	114,004	17,963	5,466	(12,497)	3-15 YRS	5,466	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	740,785	20,187	20,187			705,330	40
41	TOTALS	$ 1,409,911	$ 146,214	$ 69,032	$ (77,182)		$ 837,483	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 312,421	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 235,239	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (77,182)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,682,784	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the curre
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipm $ 23,033 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE RAM PR 2	$ 625.00	$ 10,032	17
18					18
19					19
20					20
21	TOTAL		$ 625.00	$ 10,032	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 90

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$ 344	$ 344	$	$ 688
2	Books and Supplies	45	45		90
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	50			50
9	TOTALS	$ 439	$ 389	$	$ 828
10	SUM OF line 9, col. 1 and 2 (e)	$ 828			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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ies.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 102,776	$		$ 102,776	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,353			9,353	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			169,317			169,317	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				104,967		104,967	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY & RENTALS Other (specify):	39-2					60,177		60,177	13
14	TOTAL			$		$ 281,446	$ 165,144		$ 446,590	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,908	$ 73,085	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 175,123)	1,716,224	1,716,224	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,104	150,008	6
7	Other Prepaid Expenses	20,379	20,379	7
8	Accounts Receivable (owners or related parties)	833,709	62,146	8
9	Other(specify): ESCROW DEPOSITS		40,184	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,620,324	$ 2,062,026	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		98,000	13
14	Buildings, at Historical Cost		2,111,156	14
15	Leasehold Improvements, at Historical Cost		2,894,854	15
16	Equipment, at Historical Cost	669,125	1,307,772	16
17	Accumulated Depreciation (book methods)	(323,058)	(3,135,533)	17
18	Deferred Charges	2,680	96,779	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,030,765	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 348,747	$ 4,403,793	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,969,071	$ 6,465,819	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 450,894	$ 600,996	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	238,943	238,943	28
29	Short-Term Notes Payable	2,637,213	2,741,213	29
30	Accrued Salaries Payable	87,857	87,857	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,047	12,047	31
32	Accrued Real Estate Taxes(Sch.IX-B)		93,120	32
33	Accrued Interest Payable	983	983	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,427,937	$ 3,775,159	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	217,579	217,579	39
40	Mortgage Payable		4,719,941	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 217,579	$ 4,937,520	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,645,516	$ 8,712,679	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (676,445)	$ (2,246,860)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,969,071	$ 6,465,819	48

***(See instructions.)**

Print Preview

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 545,093	1	
2	Restatements (describe):		2	
3	ROUNDING	5	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 545,098	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,221,543)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,221,543)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (676,445)	24	*

*** This must agree with page 17, line 47.**

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Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,880,599	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,880,599	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22,071	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 22,071	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**DISCOUNTS**		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 7,902,670	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,322,683	31
32	Health Care	3,324,540	32
33	General Administration	2,687,134	33
	B. Capital Expense		
34	Ownership	1,228,524	34
	C. Ancillary Expense		
35	Special Cost Centers	446,590	35
36	Provider Participation Fee	114,742	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,124,213	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,221,543)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (1,221,543)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,570	1,637	$ 52,730	$ 32.21	1
2	Assistant Director of Nursing	1,922	2,154	55,911	25.96	2
3	Registered Nurses	36,381	39,647	923,519	23.29	3
4	Licensed Practical Nurses	9,097	10,240	211,506	20.65	4
5	Nurse Aides & Orderlies	94,048	98,478	1,188,210	12.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,890	5,576	75,868	13.61	8
9	Activity Director	2,062	2,345	25,051	10.68	9
10	Activity Assistants	14,040	15,972	137,950	8.64	10
11	Social Service Workers	3,049	3,932	54,079	13.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	12,075	13,654	165,445	12.12	14
15	Cook Helpers/Assistants	17,113	17,815	127,941	7.18	15
16	Dishwashers					16
17	Maintenance Workers	1,975	2,168	29,963	13.82	17
18	Housekeepers	26,024	28,059	224,841	8.01	18
19	Laundry	9,164	10,072	83,733	8.31	19
20	Administrator	2,059	2,269	96,243	42.42	20
21	Assistant Administrator	2,422	2,758	43,874	15.91	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,115	9,924	142,168	14.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,839	9,799	129,088	13.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	255,845	276,499	$ 3,768,120 *	$ 13.63	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	240	$ 11,916	1-3	35
36	Medical Director	61	18,469	9-3	36
37	Medical Records Consultant	8	350	10-3	37
38	Nurse Consultant	1,389	51,935	10-3	38
39	Pharmacist Consultant	300	2,400	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	29	1,602	11-3	44
45	Social Service Consultant	30	1,643	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		0	10-3	47
48	UTILIZATION REVIEW FEE	14	1,400	10-3	48
49	TOTAL (lines 35 - 48)	2,071	$ 89,715		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,778	$ 108,304	10-3	50
51	Licensed Practical Nurses	2,087	70,131	10-3	51
52	Nurse Aides	2,780	53,840	10-3	52
53	TOTAL (lines 50 - 52)	7,645	$ 232,275		53

0

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KIM KOHLS	ADMIN		$ 96,243
VIVIAN MC CAIN	ASST. ADMIN		43,874
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 140,117

B. Administrative - Other

Description	Amount
FIRST HEALTH CARE --- MANAGEMENT FEES	$ 627,420
TOTAL (agree to Schedule V, line 17, col. 3)	$ 627,420
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		255,018
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 255,018

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,799
Unemployment Compensation Insurance	33,208
FICA Taxes	285,879
Employee Health Insurance	115,217
Employee Meals	4,964
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	10,066
EMPLOYEE BENEFITS-OTHER	13,734
EMPLOYEE PHYSICAL EXAMS	342
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 519,209

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	20,323
Health Care Worker Background Chec	3,487
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	108,257
DUES & SUBSCRIPTIONS	17,560
LICENSES & PERMITS	369
TRUST FEES, CONTRIBUTIONS,etc.	3,840
RELATED PARTY	1,824
LESS TRUST FEES, CONTRIB, etc.	(3,840)
Less: Public Relations Expense	( )
Non-allowable advertising	(89,575)
Yellow page advertising	(18,682)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,563

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	1,091
RELATED PARTY	12,329
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,420

**See instructions.

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Facility Name & ID Num COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	1999	$ 9,371		$	$	$ 1,562	$ 3,124	$ 3,124	$ 151	$	$	$
2	PAINT/DECORATING												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,371		$	$	$ 1,562	$ 3,124	$ 3,124	$ 151	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost rep **YES**
If YES, give association name and amo **IL COUNCIL LONG TERM CARE $6521**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this per **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. **14,492** Line **10**

(7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangeme **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII) YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. **114,742**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifie in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Secti **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportatio residents? **NO** If YES, please indicate the amount of income earned from such program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and pati **5%**
d. Have vehicle usage logs been maintair **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this co been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost repo **YES**
Attach invoices and a summary of services for all architect and appraisal fees

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Facility Name & ID Number COUNTRYSIDE CARE CENTRE #0040931 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	11916	
	REPAIRS & MAINTENANCE		1106	
			0	13022
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		2379	
			0	2379
5	HEAT & OTHER UTILITIES			
	GAS HEAT		48595	
	ELECTRICITY		63799	
	WATER		57739	
	CABLE TV - LOBBY		0	
			0	170133
6	MAINTENANCE			
	GROUNDS MAINTENANCE		16268	
	PAINTING & DECORATING		978	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		36327	
	ELEVATOR MAINTENANCE & REPAIR		4896	
	OUTSIDE LABOR		5632	
	EXTERMINATING SERVICE		5508	
	FIRE SERVICE		3426	
	DEFERRED PAINTING & DECORATING		5359	
			0	
			0	78394
7	OTHER			
	SCAVENGER		24346	
	SECURITY SERVICE		1922	26268
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	18469	18469
10	NURSING			
	CONTRACT NURSING	XVIII C53	232275	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	0	
	RESTORATIVE NURSING CONSULTA	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	350	
	PHARMACY CONSULTANT	XVIII B39	2400	
	UTILIZATION REVIEW FEES	XVIII B48	1400	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	51935	
			0	
			0	288360
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	0	
	OCCUPATIONAL THERAPY CONSUL	XVIII B41	0	
	SPEECH THERAPY CONSULTANT	XVIII B43	0	
	RESPIRATORY CONSULTANT	XVIII B42	0	0
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		9772	
	ACTIVITY REHAB CONSULTANT	XVIII B44	1602	
			0	11374
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULT	XVIII B45	0	
	SOCIAL WORKER	XVIII B45	1643	
			0	1643
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	828	828